DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	,		(X3) DATE SURVEY COMPLETED R 08/09/2011	
		155698	B. WIN				
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		00/03/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/14/11 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).		{K 0	00}			
	Survey Date: 08/09/1	11					
	Facility Number: 011 Provider Number: 15 AIM Number: 200380	5698					
	Surveyor: Phillip Kon Specialist	nsiski, Life Safety Code					
	Life Safety from Fire a NFPA (National Fire F LSC (Life Safety Cod original portion of the 01, consists of everyt	compliance with					
	determined to be Typ surveyed as two sepa construction dates of building. The facility smoke detection in th						
ARORATORY	DIRECTOR'S OR PROVIDER'S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01,02			(X3) DATE SURVEY COMPLETED	
		is a training and in the master with					
155698			B. WING			08/09/2011	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				17	EET ADDRESS, CITY, STATE, ZIP CODE 07 BETHANY RD NDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
{K 000}	Continued From page 1 Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/15/11. INITIAL COMMENTS		{K 00				
	Code Recertification a						
	Survey Date: 08/09/11						
	Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790						
	Surveyor: Phillip Komsiski, Life Safety Code Specialist						
	Life Safety from Fire a NFPA (National Fire F LSC (Life Safety Cod 20 room 600 wing wa New Health Care Occ The facility, a one sto was determined to be The facility has a fire	a compliance with ticipation in 2 CFR Subpart 483.70(a), and the 2000 edition of the Protection Association) 101, e) and 410 IAC 16.2. The s surveyed with Chapter 18, cupancies. ry, fully sprinklered building a Type V (111) construction. alarm system with smoke					
	corridors and all resid	lors, areas open to the lent sleeping rooms. The of 74 and had a census of survey.					